PALM BEACH DIABETES & ENDOCRINE SPECIALISTS, P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient giving consent

Name: _____

Address: _____

Telephone: _____ **Social Security Number:** _____

Section B: To the patient – please read the following statements carefully.

Purpose of consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations of the uses and disclosures we may make of your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice of privacy practices which will contain the changes. Those changes may apply to any protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

ATTENTION: **Practice Administrator**
ADDRESS: **1515 N. Flagler Drive, Suite 430**
West Palm Beach, FL 33401
TELEPHONE: **(561) 659-6336, extension 8026**
FAX: **(561) 659-9353**

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance of this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

Signature: _____

I, _____ have had full opportunity to read and consider the contents of this consent form and have received a copy of this practice's Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

First name: _____ **Last Name:** _____
(please print) **(please print)**

Signature _____ **Date:** _____

For office use only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement